COBRA TRAINING FACILITY

RESPIRATORY MEDICAL EVALUATION QUESTIONNAIRE

1. **PURPOSE:**

To ensure that you do not have any medical or respiratory conditions which would place you at increased risk during training, IAW 29 CFR 1910.134 App. C ; OSHA Respirator Medical Evaluation Questionnaire.

2. **PATIENT IDENTIFICATION INFORMATION**:

Date: _____

Name (please print)_____

Social Security Number: _____

Age: _____ Sex: _____ Work Telephone Number:_____

HT:_____ WT:_____ BLOOD TYPE:_____

EMPLOYER:

_____

Class Number:_____

Reviewed By:_____

FOR OFFICIAL USE ONLY

The Privacy Act of 1974, 5 U.S.C. 552A, Prohibits unauthorized release of personal data contained herein.

Routine use of the information may be used to carry out follow-up evaluations. The unauthorized disclosure of information this form could result in a violation of an individual'' right to privacy. Minimum security measures require that the information contained herein be used only by authorized persons in the conduct of official business. Unauthorized disclosure of personal information, to any person not entitled to receive it, may result in a fine not more than $5000.

COBRA TRAINING FACILITY

RESPIRATORY MEDICAL EVALUATION QUESTIONNAIRE

PLEASE MARK "YES" OR "NO" TO THE FOLLOWING QUESTIONS:

1. Can you read? _____YES _____NO

2. Have you worn a respirator, SCBA, gas mask, or Powered Air Purifying Respirator (PAPR) _____YES _____NO
   If yes, what kind: _____

3. Do you currently smoke tobacco, or have you smoked tobacco in the last month? _____YES _____NO

4. Do you have any of the following conditions?

   a. Seizures (fits) _____YES _____NO

      Any limitations or restrictions? _____YES _____NO

      Describe any limitations or restrictions _____

   b. Diabetes (sugar disease) _____YES _____NO

   c. Allergic reactions that interfere with your breathing? _____YES _____NO

      Describe _____

   d. Claustrophobia (fear of closed-in places) _____YES _____NO

   e. Heat injury in past 12 months? _____YES _____NO

   f. Heat Stroke _____YES _____NO

   g. Frequent fainting episodes? _____YES _____NO

   h. Deep cuts or sutures? Date _____ _____YES _____NO

   i. Trouble smelling odors? _____YES _____NO

   j. Myasthenia gravis _____YES _____NO

5. Have you ever had any of the following pulmonary or lung problems?

   a. Asbestosis _____YES _____NO

   b. Asthma _____YES _____NO

      Childhood only? _____YES _____NO

c. Chronic bronchitis _____YES _____NO

d. Pneumonia Date_____ _____YES _____NO

e. Emphysema _____YES _____NO

f. Tuberculosis _____YES _____NO

g. Silicosis (inhalation of silica/quartz dust) _____YES _____NO

h. Pneumothorax (collapsed lung) Date _____ _____YES _____NO

i. Lung cancer _____YES _____NO

j. Broken ribs Date_____ _____YES _____NO

k. Any chest injuries? Date_____ _____YES _____NO

l. Any chest surgery(s) _____YES _____NO

What procedure(s)_____ Date _____

Any limitations or restrictions? _____YES _____NO

Describe any limitations or restrictions _____

m. Any other lung problem that you've been told about _____YES _____NO

Describe _____

6. Do you **currently** have any of the following symptoms of pulmonary or lung illness?

a. Shortness of breath _____YES _____NO

b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline _____YES _____NO

c. Shortness of breath when walking with other people at an ordinary pace on level ground _____YES _____NO

d. Have to stop for breath when walking at your own pace on level ground _____YES _____NO

e. Shortness of breath when washing or dressing yourself _____YES _____NO

f. Shortness of breath that interferes with your job _____YES _____NO

g. Coughing that produces phlegm (thick sputum) _____YES _____NO

h. Coughing that wakes you early in the morning _____YES _____NO

i. Coughing that occurs mostly when you are lying down _____YES _____NO

j. Coughing up blood in the past month _____YES _____NO

k. Wheezing _____YES _____NO

l. Wheezing that interferes with your job _____YES _____NO

m. Chest pain when you breathe deeply _____YES _____NO

n. Any other symptoms that you think may be related to lung problems _____YES _____NO

7. Have you ever had any of the following cardiovascular or heart problems?

a. Heart attack _____YES _____NO

b. Stroke _____YES _____NO

c. Angina _____YES _____NO

d. Heart failure _____YES _____NO

e. Swelling in your legs or feet (not caused by walking) _____YES _____NO

f. Heart arrhythmia (heart beating irregularly or skipping a beat) Date _____ _____YES _____NO

Any limitations or restrictions? _____YES _____NO

Describe any limitations or restrictions _____

g. High blood pressure _____YES _____NO

h. Any other heart problem that you've been told about _____YES _____NO

Describe _____

Any limitations or restrictions? _____YES _____NO

Describe any limitations or restrictions _____

8. Have you ever had any of the following cardiovascular or heart symptoms?

a. Frequent pain or tightness in your chest _____YES _____NO

b. Pain or tightness in your chest during physical activity _____YES _____NO

c. Pain or tightness in your chest that interferes with your job _____YES _____NO

d. Heartburn or indigestion not related to eating _____YES _____NO

Describe _____

e. Any other symptoms that you think may be related to heart or circulation problems _____YES _____NO

9. Do you currently take medication for any of the following problems?

a. Breathing or lung problems _____YES _____NO

b. Heart trouble _____YES _____NO

c. Blood pressure _____YES _____NO

d. Seizures (fits) _____YES _____NO

e. Other medical problems _____YES_____NO

10. LIST all medications:

Name of Medication	Dosage	Frequency

11. If you've used a respirator, have you ever had any of the following problems? If you **have never** used a respirator, **check the following space** and go to Question 12 _____

a. Eye irritation _____YES _____NO

b. Skin allergies or rashes _____YES _____NO

c. Anxiety _____YES _____NO

d. General weakness or fatigue _____YES _____NO

e. Hyperventilation in mask _____YES _____NO

f. Any other problems that interfere with your use of a respirator _____YES _____NO

12. Have you ever lost vision in either eye (temporarily or permanently)? Date _____ _____YES _____NO

Describe _____

Any limitations or restrictions? _____YES _____NO

Describe any limitations or restrictions _____

13. Do you currently have any of the following vision problems?

a. Wear contact lenses _____YES _____NO

b. Wear glasses _____YES _____NO

c. Color blind _____YES _____NO

d. Any other eye or vision problems Date _____ _____YES _____NO

Describe _____

Any limitations or restrictions _____YES _____NO

Describe any limitations or restrictions _____

14. Have you ever had an injury to your ears, including a broken eardrum? Date_____ _____YES _____NO

Describe injury _____

15. Do you currently have any of the following hearing problems?

a. Difficulty hearing _____YES _____NO

b. Wearing a hearing aid _____YES _____NO

c. Any other hearing or ear problems _____YES _____NO

Describe _____

16. Have you ever had a back injury? Date_____ _____YES _____NO

Any limitations or restrictions? _____YES _____NO

Describe any limitations or restrictions _____

17. Do you currently have any of the following musculoskeletal problems?

a. Weakness in any of your arms, hands, legs, or feet _____YES _____NO

b. Back pain _____YES _____NO

c. Difficulty fully moving your arms and legs _____YES _____NO

d. Pain or stiffness when you lean forward or backward at the waist _____YES _____NO

e. Difficulty moving your head up or down _____YES _____NO

f. Difficulty moving your head from side to side _____YES _____NO

g. Difficulty bending at your knees _____YES _____NO

h. Difficulty squatting to the ground _____YES _____NO

i. Climbing a flight of stairs or ladder carrying more than 25 lbs _____YES _____NO

j. Any other muscle or skeletal problem that interferes with wearing a respirator _____YES _____NO

k. Do you NORMALLY wear any form of back brace or other form of brace or prosthesis? _____YES _____NO

Describe _____

18. Are you pregnant? _____YES_____NO_____NA

19. Do you have any other medical problems not mentioned on this questionnaire? _____YES _____NO

Describe _____

20. Are you limited or restricted for any medical issues? _____YES _____NO

Describe _____

21. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire? _____YES _____NO